GOVERNMENT OF THE DISTRICT OF COLUMBIA

CRFMR
Rev. 9/02

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility:	Street Address, City, State, ZIP Code:	Survey Date:
The Georgetown	2512 Q St., NW Washington, DC 20007	05/04/09 Follow-up Dates(s):

Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date
Assisted Living Residence Law 13-127 Act 13-297	An Annual licensure survey was conducted on May 4, 2009, to determine compliance with Assisted Living Residence Law 13-127 and Act 13-297. The following deficiencies were based on record reviews, observations and interviews. The sample sizes were eight (8) resident records based on a census of eighty (80) residents and six (6) employee records based on a census of sixty-two (62) employees.		Received 7/23/09 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
	502 **SELF-DETERMINATION, CHOICE, INDEPENDENCE, PARTICIPATION AND PIVACY**			
502	**(a) A resident shall have the right to be treated at all times as follows:**			

Name of Inspector — Date Issued: 05/13/09

Facility Director/Designee — Date: 7/20/09

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(1) Courteously;

(2) Respectfully;

Based on an observation it was determined that an employee of the facility failed to treat a resident courteously and respectful. (Resident #8)

The finding includes:

An observation on May 5, 2009 at approximately 12:30 pm revealed that resident #8 asked an employee of the dining room staff for some margarine for her sandwich. At that time, she made the employee aware that an inspector was there to survey the dinning area and to make sure everything was being done correctly. While moving her hands in the air the employee stated " Oh is that why you graced us with your presence today? Anyway, this is not my side of the dining room, but I will help you with what you need. You said you wanted margarine, but would you like mayonnaise or mustard and how many packs do you want? One, two or three, but like I said I have to make sure my side is fine before I can help you. It will be a few minutes." The resident then looked at the

A PRELIMINARY MEETING WITH DINING ROOM STAFF WAS CONDUCTED BY MANAGEMENT STAFF TO DISCUSS COURTESY AND RESPECT OF RESIDENTS. 6/15/09

IN ADDITION, A FULL IN-SERVICE WAS CONDUCTED BY FLIK INTERNATIONAL, A CONTRACTED FOOD SERVICE PROVIDER. THIS IN-SERVICE INCLUDED REINFORCEMENT OF COMPANY POLICIES ON RESIDENT RIGHTS, PROPER DINING ROOM SERVICE 6/30/09

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	surveyor and stated "I feel like I'm bothering them when I ask for something that's why I eat in my room a lot. I think it is disrespectful the way the staff talks sometimes and it happens all the time when I talk with her". A few minutes later the employee did return with several packs of mayonnaise. **604** **INDIVIDUALIZED SERVICE PLANS**	AND TECHNIQUES. THIS IN-SERVICE WILL BE CONDUCTED 2 TIMES PER YEAR. STAFF WILL BE MONITORED CLOSELY FOR COMPLIANCE.	
604 (a) (1)	**(a) (1) An ISP(Individualized Service Plan) shall be developed for each resident prior to admission.** Based on a record review , it was determined the facility failed to develop an ISP prior to admission for one (1) of one(1) patients (Resident #4) The finding includes: A record review of resident #4's record on May 5, 2009 at approximately 1:00 PM, revealed that he had been admitted on May 4, 2009. The resident's medical, rehabilitation, psychosocial and functional assessments, which are used to develop the Individual Service Plan (ISP), were completed on	PRE ADMISSION ISP's ARE TO BE COMPLETED BY THE ADMISSION TEAM. A CHECK LIST WILL BE CREATED TO ENSURE THAT ALL NESSESARY PAPERWORK IS COMPLETED TIMELY FOR EACH ADMISSION. CHECKLIST AND PAPERWORK WILL BE REVIEWED BY THE ALA FOR EACH ADMISSION.	6/30/09

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	April 30, 2009, however failed to evidence that an ISP was developed.	#1	ISP UPDATED	6/30/09
		#2	ISP UPDATED	6/30/09
	604 INDIVIDUALIZED SERVICE PLANS	#3	ISP UPDATED	6/30/09
		#4	ISP UPDATED	6/30/09
604 (b)	**The ISP shall include the services to be provided, when and how often the services will be provided and accessed.**		RESIDENT ISP'S WILL BE UPDATED WHEN SIGNIFICANT CHANGES OCCUR. (I.E. CHANGES IN HEALTH STATUS, COGNITIVE ABILITY, DIETARY CHANGES, TREATMENT CHANGES, P.T., O.T., WOUND CARE, ETC.	
	Based on record reviews, it was determined the facility failed to include all services provided on the Individual Service Plan's (ISP) for four (4) of eight (8) ISP's reviewed. (Resident's # 1,#2,#3,#6)			
	The findings include:			
	1. A record review of resident #1's record on May 5, 2009 at approximately 10:30 am, revealed that the resident had order dated 12/9/08 for dressing change to right foot daily. Nursing notes dated 04/20/09 and 04/21/09 indicated that resident was receiving physical therapy.			
	Further review of the record revealed an ISP dated 01/09/09 which did not include the aforementioned		NURSING WILL INITIATE CHANGES TO ISP'S BY IMMEDIATELY RECORDING NEW TREATMENT MODALITIES AND CHANGES IN RESIDENT	

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mentioned services.

2. A record review of resident #2's record on May 5, 2009 at approximately 11:00 am, revealed a document named "Assessment for Self-Administration of Medications" dated 12/17/08, which indicated that resident approval to self medicate, was not granted due to confusion of the resident.

Further review of the record revealed an ISP dated 01/12/09, which indicated that the resident self-medicated with no assistance needed.

3. A record review of resident #3 revealed a physician order dated 04/19/09 for 1600 cal, No Added Salt (NAS) pureed diet, with honey thick liquids and aspiration precautions.

Further review of the record, revealed an ISP dated 01/15/09 which indicated that the resident was to receive a low sodium, soft diet. The aforementioned diet change and aspiration precaution was not updated on the ISP dated 01/15/09.

An observation of resident #2's meal tray on May 5, 2009 at approximately 3:00 PM revealed the patient had eaten approximately fifty percent of a

PHYSICAL, MENTAL, OR SENSORY STATUS AS THEY OCCUR. A REVIEW OF THE ISP WILL BE CONDUCTED BY THE ISP TEAM EVERY SIX MONTHS TO ENSURE THAT THE IDENTIFIED SERVICE IS CONDUCIVE TO MEETING THE RESIDENT'S NEEDS.

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pureed diet.

4. A record review of resident #6 at approximately 2:45 PM, revealed an ISP dated 01/28/09 which indicated the resident is independent in mobility. It also stated "please see comment... and that assistance was needed with mobility on an as needed bases", however the comment section and the department providing services section were both blank.

Further review of the record revealed that the resident fell on 01/27/09 at 1:30 AM while being assisted.

701
Staffing Standards

(d) An ALA (Assisted Living Administrator) shall:

(1) Employ staff and develop a staffing plan in accordance with this act and based upon the following criteria to assure the safety and proper care of residents in the ALR:

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(D) The capabilities and training of the employees;

Based on an observation and record review, it was determined that the ALA failed to ensure that an employee #1 was capable of performing proper care of one (1) of one (1) resident receiving dressing changes. (Resident #1)

The finding includes:

An observation on May 5, 2009 at approximately 11:00 am, revealed the following:

Employee #1 failed to maintain infection control while performing a dressing change for resident #1. Employee #1 removed the resident's previous dressing and never changed contaminated gloves prior to performing dressing change. Employee #1 did not use a clean field to place resident's wound on, while changing his dressing. Employee #1 allowed the resident to sit his open wound on his personal, un-cleaned coffee table. The medication she used did not have a top. The medication was covered with a paper towel and rubber band. Employee #1 admitted to the top being lost.

EMPLOYEE #1

AN IN-SERVICE ON PROPER WOUND DRESSING PROCEDURES WAS CONDUCTED ON MAY 21. ALL LICENSED NURSES (DAYLIGHT) WERE PRESENT INCLUDING EMPLOYEE #1. EMPLOYEE #1 WAS OBSERVED PERFORMING A DRESSING CHANGE. PROPER TECHNIQUES WERE USED. PERIOTIC OBSERVATIONS WILL BE CONDUCTED TO ENSURE THAT PROPER DRESSING TECHNIQUES CONTINUE TO BE USED. THE ANNUAL IN-SERVICE TRAINING SCHEDULE WILL INCLUDE INFECTION CONTROL AND PROPER WOUND CARE.

5/21/09

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	Employee #1 used her contaminated gloved finger to remove medicine from the container. Employee #1used an opened undated bottle of saline that was in the resident's room to clean his wound. The employee then discarded the contaminated dressing in the resident's personal trash can. A record review on May 5, 2009 at approximately revealed 12:00 pm revealed a physician's order dated 12/09/08 which ordered to apply silver sulfadiazide1%gm under right foot every day then cover with a sterile dressing. There was documented evidence of an order for normal saline which was used by employee #1 to cleanse resident's wound. **802** **MEDICAL,REHABILITATION, AND PSYCHOSOCIAL ASSESSMENT**				
802 (a)	**A medical, rehabilitation, and psychosocial assessment of the resident shall be completed within 30 days prior to admission a medical, rehabilitation, and psychosocial** Based on a record review, it was determined that the facility failed to have a medical, rehabilitation and psychosocial assessment on standardized				

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forms approved by the Mayor for four (4) of eight (8) resident's. (Resident #2, #3, #7, #8)

The findings include:

1. A record review of resident #2's record on May 5, 2009 at approximately 11: 30 am, revealed a form entitled "Admission/Annual Medical Certificate" dated February 26, 2008 approved by the Mayor for Community Resident Facilities. There was no documented evidence that an assessment had been completed prior to admission on the standardized form approved by the Mayor for Assisted Living Facilities.

2. A record of resident #3's record on May 5, 2009 at approximately 10:20 am revealed a form entitled "Admission/Annual Medical Certificate" dated January 27, 2008 approved by the Mayor for Community Resident Facilities .There was no documented evidence that an assessment had been completed prior to admission on the standardized form approved by the Mayor for Assisted Living Facilities.

3. A record review of resident #8 record on May 5, 2009 at approximately 11: 30 am revealed a form entitled "Admission/Annual Medical

#1	RESIDENT #2 IS SCHEDULED FOR HER ANNUAL Medical.	7/23/09
#2	RESIDENT #3's DOCTOR HAS ANNUAL CERTIFICATE AND WILL COMPLETE ASAP.	7/21/09
#3	RESIDENT #8's DOCTOR HAS ANNUAL CERTIFICATE AND WILL COMPLETE ASAP.	7/21/09
#4	RESIDENT #7 RECORD HAS BEEN REVIEWED AND VERIFIED BY THEIR DOCTOR AND UPDATED.	7/2/09
	NURSE: A REVIEW OF THE CHEST X-RAY AND CONSULTATION WITH THE RESIDENT'S DOCTOR REVIELED THAT HER DOCTOR RECEIVED A COPY OF THE	

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	by the Mayor, the following information regarding each applicant:				
803 (1)	(1) Level of functioning in activities of daily living including bathing, dressing, grooming, eating, toileting, and mobility;				
803 (2)	(2) Level of support and intervention, including any special equipment and supplies, required to compensate for the individual's deficit in activities of daily living;				
803 (3)	(3) Current physical or psychological symptoms of the individual requiring monitoring, support, or other intervention by the ALR;				
803 (4)	(4) Capacity of the individual for making personal and healthcare related decisions;				
803 (5)	(5) Presence of disruptive behavior or behavior which presents a risk to the physical or emotional health and safety of self or others;				
803 (6)	(6) Social factors, including:				
	(A) Significant problems with family				

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	Certificate" dated February 2008 approved by the Mayor for Community Resident Facilities. There was no documented evidence that an assessment had been completed prior to admission on the standardized form approved by the Mayor for Assisted Living Facilities.	X-RAY ON 2/10/09 AND NO TREATMENT WAS ORDERED AT THAT TIME. RESIDENT RECORD UPDATED
802 (a)	4. A record review on May 5, 2009 of resident #7 record at approximately 2pm revealed a standardized form DOH named "Admission/Annual Medical Certification" dated 02/10/09 however the resident name had been omitted from the document. Further review of the record revealed an chest x-ray with impression: Haziness left base. Cannot rule out left basilar infiltrate and/or small pleural infusion dated 02/09/09. There was no documented evidence in record that nursing staff had followed up on the findings of the chest x-ray.	THE CARD FILE THAT IS USED TO TRACK ANNUAL MEDICAL CERTIFICATIONS HAS BEEN UPDATED. THIS CARD FILE WILL BE REVIEWED MONTHLY AND UTILIZED TO ENSURE THAT ANNUAL MEDICAL CERTIFICATIONS ARE SCHEDULED IN A TIMELY MANNER.
	803 **FUNCTIONAL ASSESSMENT** **Within 30 days prior to admission, the facility shall collect, on a standardized form approved**	

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803 (6) (A)	**circumstances and personal relationships;**	
803 (6) (B)	**(B) Spiritual problem with family circumstances and personal relationships;**	
803 (6) (C)	**(C) Ability to participate in structured and group activities and the resident's current involvement in such activities.**	
	Based on a record review, it was determined that the agency failed to have a functional assessment for one (1) of eight (8) resident's. (Resident #7)	
	The findings include:	RESIDENT #7 FILE RECORD HAS BEEN VERIFIED BY PHYSICIAN AND UPDATED WITH RESIDENT NAME. ALL ADMISSION/ANNUAL MEDICAL CERTIFICATES WILL BE REVIEWED FOR COMPLETE AND PROPER DEMOGRAPHICS PRIOR TO ENTRY INTO THE RESIDENT RECORD.
	A record review on May 5, 2009 of resident #7 record at approximately 2pm revealed a standardized from DOH named "Admission/Annual Medical Certification" dated 02/10/09 however the resident name had been omitted from the document.	

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	901 **RESPONSIBILITIES OF THE ALR PERSONNEL IN MEDICATION MANAGEMENT**				
	An ALA shall ensure that an initial assessment identifies whether a resident:				
901 (1)	**(1) Is capable of self-medicating his or her own medication;**				
902 (2)	**(2) Is capable of self-administering his or her own medication, but requires a reminder to take medication or requires physical assistance with opening and removing medications from the container, or both; or**				
902 (3)	**(3) Requires that medications be administered by TME (Trained Medication Aide) or a licensed nurse.**				
	Based on a record review and interview, it was determined that the facility failed to ensure that one (1) of three (3) resident's had a self-medicating assessment performed. (Resident #5)				

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	The findings include: A record review on May 5, 2009 at approximately 1:30 pm revealed a nursing note dated 09/28/08, indicated that resident #5 self-medicates. There was no documented evidence in the resident record of a self-medicating assessment. Further review of the record revealed an ISP dated 01/13/09 which indicated that the resident self-medicated with no assistance needed. A face to face interview was conducted with employee #1 who indicated that resident #5 self-medicates.	A REVIEW OF ALL RESIDENT FILES THAT ARE SELF MEDICATING. THESE FILES ARE UP TO DATE AND HAVE A COMPLETE "SELF MEDICATION ASSESMENT" FORM IN THE RECORD. THE DIRECTOR OF HEALTH SERVICES WILL REVIEW AND/OR UPDATE SELF MEDICATION ASSESMENTS AT THE RESIDENT ISP MEETINGS AND AT ANY TIME THE RESIDENT HAS A CHANGE OF STATUS THAT MAY EFFECT THEIR ABILITY TO SELF MEDICATE.
	1004 **GENERAL BUILDING INTERIOR**	
1004 (a)	**(a) An ALR shall ensure that the interior of its facility, including walls, ceilings, doors, windows, equipment, and fixtures are maintained structurally sound, sanitary, and in good repair.**	

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Based on observations on May 5, 2009, it was determined the facility failed to maintain the building interior in a sanitary manner and in good repair. The findings include. 1. Three (3) ceiling lights in the activity room, were observed with dead bugs in the cover lenses. 2. Apartment #325 had a TV cable that was loose and not securely connected to the wall. 3. Three (3) lens covers for the kitchen ceiling lights were missing. 4. The light over the dishwashing sink was not working. 5. There was a leaking faucet above the pot sink. 6. Wall tiles were missing under the pot sink. 7. The dining room ceiling, in front of the patio door, was noted with air pockets. Above findings were acknowledged by the General Manager on May 5, 2009.	#1	ALL COVER LENSES HAVE BEEN CLEANED AND BUGS REMOVED.	6/25/09
	#2	TV CABLE HAS BEEN SECURED.	5/6/09
	#3	LENS COVERS REPLACED	6/1/09
	#4	LIGHT BULBS REPLACED	6/1/09
	#5	FAUCET REPLACED	5/12/09
	#6	WALL TILES REPLACED	5/9/09
	#7	DRY WALL REPAIR AND PAINTING SCHEDULED	8/15/09

A COMPLETE WALK THROUGH OF THE BUILDING BY MANAGEMENT STAFF WILL BE CONDUCTED AT LEAST EVERY 6 MONTHS TO ENSURE PROPER BUILDING MAINTENANCE